

ER PHYSICIAN HOTLINE

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Thanks to Dr. Dillard and Dr. Way for contributing these articles. Questions or comments may be directed to them at:

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TRIAGE VERSUS MEDICAL SCREENING

BY W. LEIGH DILLARD, MD

There appears to be some confusion regarding triage and medical screening exams. The difference between the two is like night and day. The purpose of this article is to attempt to clarify that difference. Misuse of the process can result in EMTALA and COBRA violations.

Triage should refer to a process of medically evaluating patients for treatment in an order of priority based on the severity of their illness or condition. Triage should not be used to determine suitability for treatment in an ER setting. Medical personnel have carried out triage since before the word was even invented. It is a process so that the person most in need of care could be identified and treated before attending to the less severely afflicted. No one can argue that the gunshot wound to the chest should be treated before the sinus allergy that has been present for two weeks.

Medical screening on the other hand is a relatively new term as it is used in the EMTALA guidelines. As we are all aware, every person presenting to an ER is entitled by law to a medical screening exam. There continues to be no clear definition of what this constitutes. For the present time, it should mean to ER personnel that the patient has had an evaluation thorough enough to assure that no condition is present which could be expected to adversely affect the patient's life or limb within the next 72 hours. The real trick here is to provide consistent, non-biased evaluations. Continue the evaluation until the above endpoint is reached no matter what tests are required.

It should be obvious by now that **TRIAGE is a medical term** and **MEDICAL SCREENING is a legal term** (TRAP).

I have heard ER personnel state, "That patient was tri-

aged out of the ER." You cannot triage a patient out. Triage can only set the order in which patients are evaluated. In this context, the word triage is indefensible and a medical curse word.

The nursing staff alone cannot perform a medical screening exam for purposes of determining suitability of a patient to be seen in the ER setting. There must be physician input to this determination.

The medical screening exam should be determined by the local medical staff, approved by the governing board of the hospital and consistently applied on a non-discriminatory basis by the ER staff if used. If this is not formulated in the hospital you serve, each patient should be seen, evaluated and treated without derogatory comment by the ER staff.

Any further questions should

SNAKEBITE UPDATE

BY PETER WAY, MD

We have had a recent rash of snakebite attacks at several of our facilities, all by pit vipers. I would like to update you as to recent changes and review current thinking on pit viper attacks.

Pit Vipers characteristically are identified by a "slit eye," which is universal and distinctive for them in North America. They account for 90% of all USA snakebites. The heads of these creatures can continue to bite up to 4 days after being killed or cut off

due to an anatomic trigger mechanism, so please handle with care if presented with the actual snake. The venom causes local damage, hemorrhage, extreme swelling, and

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WAYS TO TRIGGER A MALPRACTICE SUIT

BY W. LEIGH DILLARD, MD

Malpractice suits are not always filed for medical mistakes or oversights. Sometimes the patient or patient's surviving family has a "bone to pick" with the treating physician. Examples of this phenomenon are: do not understand what happened; felt the physician did not care what happened; felt they were treated rudely; felt they were overcharged for the service; felt the physician did not listen to them; felt the physician did not examine them; someone said something to make them think all was not right; etc. Sometimes the patient or patient's family feel too confident in the physician and accept his opinion as unerring. In this setting, they may not seek follow-up even though they are not improving. If they are not confident in the physician, they will usually seek follow-up even before they should. There is risk in being too optimistic about

the suspected outcome.

There is risk in having too good a reputation as a physician as people may have unrealistic expectations. Sometimes the physician is just in the wrong place at the wrong time. There are situations in which nothing goes right even with the best of knowledge and effort. Everyone presenting for medical care will not be fully cured even in the best setting. In today's litigious climate, here are some ways to risk a malpractice suit that have little to do with poor medical care:

- Be a medical doctor treating sick people (moderate risk)
- Be a medical doctor treating trauma (high risk)
- Be rude to the patient or family (moderate risk)
- Be rude and have things go bad (high risk)

- Even if you know what is wrong: do not touch the patient (moderate risk); do not make eye contact and listen (moderate risk); do not listen to or touch the patient (high risk)
- Get involved in a no win situation (guaranteed)
- Do not give clear watch for signs requiring follow-up (high risk)
- Show no compassion (moderate risk)
- Show no compassion and things go bad (guaranteed)

The above ways to risk a malpractice action do not mean you will lose the suit, but the hassle of fighting a malpractice suit is physically and mentally painful and best avoided if possible.

"... BUT THE HASSLE OF FIGHTING A MALPRACTICE SUIT IS PHYSICALLY AND MENTALLY PAINFUL AND BEST AVOIDED IF POSSIBLE."

W. LEIGH DILLARD, MD

SNAKEBITE UPDATE (CONTINUED FROM PAGE 1)

BY PETER WAY, MD

tissue destruction. Systemically, you might see fever, increased WBC, decreased platelets, increased PT and PTT, rhabdomyolysis, or blood in the UA. "Though they can be fatal with cardiac or renal failure, generally they are not fatal. The most common severe complication is compartment syndrome, emergently requiring fasciotomy in the ER if the limb becomes ischemic.

The treatment is very controversial. There are no national standards and every poison control center called will likely give you different recommendations. The treatment is divided between conservative care, anti-venom, or surgical treatment consisting of fas-

ciotomy and surgical debridement. Often conservative care with copious IVF, antibiotics, pain management, anti-inflammatory drugs, and close observation to prevent compartment syndrome is all that is required. BMP, CBC, EKG, PT and PTT, CPK and UA should be obtained as a baseline study. The attending physician and a surgeon (if possible) should be consulted. Admission for hospitalization/observation should be obtained, unless systemic symptoms suggest transfer to an ICU.

Anti-venom treatment has recently improved with the advent of synthetic anti-venom, with fewer side ef-

fects than the serum derived anti-venom. However, this is an unpopular therapy in Texas and presently only available at Wichita Falls. The manufacturer informed me that there is no stock of either pit viper anti-venom currently available. The therapy is extremely expensive requiring 5 vials for minor symptoms to 15 vials for severe symptoms at \$2,000 per vial. I will try to keep you updated. If you have any questions, please e-mail me at pcway1962@yahoo.com.

RECURRING COMPLAINTS DEALT WITH BY THE CHIEF MEDICAL OFFICER

BY W. LEIGH DILLARD, MD

I didn't just fall off the turnip truck. I have done ER work for many years. Believe me when I say I understand the pressures of your job. This article is in no way critical of your performance, but rather informative in regards to how the various ED's perceive you.

Overall, the Physicians who staff ER's for ESS do a fantastic job. In terms of the number of patient encounters, complaints occur in a very small percentage. Unfortunately, I don't get to hear the good stuff, just the problems or complaints from patients or Hospital staff.

Here are some of the best suggestions I could give you for continued success in your field. These suggestions are based on actual events I have had to deal with:

- **Please get a pregnancy test** and do a pelvic exam on women of childbearing age who present with lower abdominal pain, or any abdominal pain in which you are not absolutely sure of the diagnosis.
- **Please get a CT scan** on elderly patients who fall and hit their head. If you don't feel a CT is indicated, document a full neurological exam, and hold for observation. Remember, their brains are atrophic and the subdural vessels are stretched, making them more likely to tear.
- **Please be courteous and kind**, just like you would want yourself or your family to be treated.
- **Please admit** all patients you feel uncomfortable with. If there is some reason you feel uncomfortable, listen to your instincts.
- **Please be respectful** of the ER staff you work with. You make no brownie points with a haughty attitude. At the same time, you do make brownie points with an air of confidence when giving clear orders.
- **Please do not be verbally critical** of ER personnel in front of patients, their families, or the other members of the ER staff. If there is a problem, write it down and communicate it to their supervisor or to me. If you don't feel inclined to write it down, then it was probably minor and will work itself out.
- **Please feel comfortable** with telling a patient you are not sure of their diagnosis if you're not. They are comfortable with this if they feel you cared and tried your best. Follow-up visits or further testing are well received when appropriate. Tell them if you don't see any problem on the x-ray, but let them know a specialist will read it later.
- **Please leave your personal problems** outside, to be dealt with on your own time.
- **Please get adequate rest.** Remember, there is not enough money and, if there was, the government would get half of it anyway.
- **Please show up on time** and stay until your replacement arrives.
- **Please document clearly** on every record. You never know which one will be reviewed by someone for some problem. You have no better friend than a well-documented medical record.
- **Please put your hands** on the patient. We all have become too dependent on ancillary testing. The well-done history and hands-on physical exam will make most of your diagnoses, and ancillary testing can then be focused to confirm your suspicions. You can't believe how many times I hear, "that doctor didn't even put his hands on me."

Remember these few suggestions. One of them will save you a lot of grief. Keep up the good work and, until next time, I wish you Godspeed.

"You can't believe how many times I hear, 'That doctor didn't even put his hands on me.'"

W. LEIGH DILLARD, MD

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MEMO TO HOSPITALISTS

By W. Leigh Dillard, MD

The first and foremost priority is good patient care, appropriate and attentive. Following very close behind is fiscally responsible patient care. The financial health of the hospital system is important in many ways to continue the quality inpatient and outpatient care you deliver. If the hospital system remains financially strong, more staff can be supported, capital expense can be more liberal, and supplies can be of better quality. With this in mind, I encourage you to examine your practice patterns for wasteful use of hospital resources. Here are suggestions to accomplish cost control and to support your hospital systems:

1. **Manage Length of Stay** by keeping a patient in the acute setting longer than necessary. This sounds simple and actually is. By relying on the patient care coordinator early in the admission, the timing of the discharge or transfer to SNF can almost always be reduced. Avoid delaying the discharge due to procrastination. Discharge criteria from the ICU can be formulated and adhered to. For non-acute problems discovered during the admission, defer those workups, when appropriate, to the outpatient setting or at least the SNF setting.
2. **Monitor Antibiotic Usage** by limiting the formulary. There are many cephalosporins, several fluoroquinolones, several anti-pseudomonals, and several different agents to cover for anaerobes. If the hospital pharmacy has to keep all these in stock because some physicians prefer different antibiotic names over others that are equally as effective, the cost of inventory can skyrocket. The group can get together and decide on one first generation, one second generation, and one third generation cephalosporin, and eliminate a large stock inventory right there. Clinical pathways can also be developed which streamline care to the diagnosis. Switch to oral therapy as soon as clinically appropriate.
3. **Utilize Swing Beds** by transferring the patient to that setting for endoscopies, scans, wound care, rehab, completion of antibiotic regimen, regulation of insulin requirements, etc. Many procedures are reimbursed at outpatient rates when done in this setting. In the acute care setting, the cost is included in the DRG payment.
4. **Limit Redundant and Unnecessary Testing** by not ordering tests by reflex, but rather by thought. Is there really a rationale for ordering a PTT on a patient not on heparin? If you are suspecting a coagulation problem, there are more appropriate tests. Do you really need a C&S on every urine specimen, or can there be criteria set up with the lab on which urines to send for culture? How often do you really need that BMP run, every 8 hours or is daily just as helpful? There are many other examples of this cost saving behavior.
5. **Utilize the Patient Care Coordinator** early in the admission, since he or she may know the family of the patient or resources of the community better, and may more rapidly formulate a plan for discharge. This way is more efficient than trying to get the entire discharge plan organized on the last day.

Please keep these suggestions in mind as you direct the hospital orchestra. The cost savings are enormous, and can allow for a more financially stable health system.